ARC 1447C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 75, "Conditions of Eligibility," Iowa Administrative Code.

These amendments are required in order for the Department to be in compliance with the Patient Protection and Affordable Care Act, which amends the current Health Insurance Payment Plan (HIPP) statute at 42 U.S.C. 1396e-1. These amendments also eliminate obsolete references to the IowaCare program and Medicare supplemental policies.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 1368C** on March 5, 2014. The Department received no comments on these amendments. These amendments are identical to those published under Notice of Intended Action.

The Council on Human Services adopted these amendments on April 9, 2014.

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments will become effective on July 1, 2014.

The following amendments are adopted.

ITEM 1. Rescind subrule **75.21(1)**.

ITEM 2. Renumber subrules **75.21(2)** to **75.21(17)** as **75.21(1)** to **75.21(16)**.

ITEM 3. Amend renumbered paragraph **75.21(1)"b"** as follows:

b. The health plan is cost-effective as defined in subrule ~~75.21(3)~~ 75.21(2).

ITEM 4. Amend renumbered subrule 75.21(4) as follows:

75.21(4) *Exceptions to payment.* Premiums shall not be paid for health insurance plans under any of the following circumstances:

a. to *f.* No change.

g. The person is eligible only for a coverage group that does not provide full Medicaid services, such as the specified low-income Medicare beneficiary (SLMB) coverage group in accordance with subrule 75.1(34) ~~or the IowaCare program in accordance with the provisions of 441—Chapter 92~~. Members under the medically needy coverage group who must meet a spenddown are not eligible for HIPP payment.

h. and *i.* No change.

~~*j.* The insurance is a Medicare supplemental policy and the Health Insurance Premium Payment Application, Form 470-2875, was received on or after March 1, 1996.~~

~~*k.*~~ *j.* The person has health coverage through Medicare. If other Medicaid members in the household are covered by the health plan, cost-effectiveness is determined without including the Medicare-covered member.

~~*l.*~~ *k.* The health plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).

~~*m.*~~ *l.* The health plan pays secondary to another plan.

~~*n.*~~ *m.* The only Medicaid members covered by the health plan are currently in foster care.

~~*o.*~~ *n.* All Medicaid members covered by the health plan are eligible for Medicaid only under subrule 75.1(43). This coverage group requires the parent to apply for, enroll in, and pay for coverage available from the employer as a condition of Medicaid eligibility for the children.

ITEM 5. Amend renumbered subrule 75.21(10) as follows:

75.21(10) *Reviews of cost-effectiveness and eligibility.* Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

a. and *b.* No change.

c. Failure of the household to cooperate in the review process shall result in cancellation of premium payment ~~and may result in Medicaid ineligibility as provided in subrule 75.21(1)~~.

d. and *e.* No change.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph ~~75.21(16)*"a,"*~~ 75.21(15)*"a,"* shall be considered if available and cost-effective.

g. No change.

ITEM 6. Amend renumbered subrule 75.21(11) as follows:

75.21(11) *Time frames for determining cost-effectiveness.* The department shall determine cost-effectiveness of the health plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule ~~75.21(8)~~ 75.21(7)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

ITEM 7. Amend renumbered paragraph **75.21(15)"c"** as follows:

c. For both group and individual health plans, if another household member must be covered to obtain coverage for the Medicaid members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(2) and 75.21(3) ~~and 75.21(4)~~.

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 4/30/14.